Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
51-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ABSOLUTE WELLNESS CENTER
601 E. WHITESTONE BLVD. STE 230
CEDAR PARK TX 78613

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
SOUTHWESTERN BELL TELEPHONE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-09-A991-01

MFDR Date Received
June 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: On 09/04-05/2008 partial payments received in the amounts of $54.14 and $1422.18; on 10/07-8/2008 partial payments received in the amounts of $74.28 and $153.14; and on 11/05/2008 partial payment received in the amount of $177.07."

Amount in Dispute: $2,093.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor seeks reimbursement for physical therapy services provided to the Claimant. The Carrier paid for physical therapy for the first 6 visits. Rule 134.600(p)(5) states that physical therapy must be preauthorized except for the first six visits within the first 2 weeks of the date of injury or surgical intervention. Therefore, all other physical therapy treatments were denied beginning on 7/16/08 as preauthorization was not obtained."

"Because preauthorization was not obtained for the physical therapy sessions provided from 7/16/08 through 10/1/08, reimbursement should not be owed."

Response Submitted by: Downs♦Stanford, PC; 2001 Bryan Street, Suite 4000; Dallas Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2008	99213-25	$ 65.00	$ 65.00
July 3, 2008	97032-59-GP	$ 40.00	$ 40.00
July 11, 2008	97112-59-GP	$ 70.00	$ 70.00
July 15, 16, 17, 21, 23-24, 28-29, 2008	97112-59-GP 97530-59-GP	$1285.00	$ 00.00

	97012-59-GP 97032-59-GP 97140-59-GP		
August 4, 6, 19, 26, 2008	97112-59-GP 97530-59-GP 97012-59-GP 97032-59-GP	$460.00	$ 00.00
September 2, 2008	97112-59-GP 97012-59-GP	$ 55.00	$ 00.00
September 2, 2008	98940-AT-GA	$ 32.00	$ 31.85
October 1, 2008	97140-59-GP 97012-59-GP	$ 86.00	$ 00.00
		Total Due	$206.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 defines all services requiring preauthorization
3. 28 Texas Administrative Code §102.3 defines a period of time such as days.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 2, 3, 17, 2008 and October 3, 2008
   - 01J – significant separately identifiable E/M service rendered
   - 4TF – charges exceed your contracted/legislated fee arrangement
   - 08K – the charge for this procedure exceeds the fee schedule allowance
   - 4VB – workers compensation state fee schedule adjustment
   - 02D – service performed was distinct or independent from other services performed on the same day
   - 0GT – this procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code
   - 4V5 – claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
   - 06Q – the charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 4UV – payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 04N – billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
   - 4VH – benefit maximum for this time period or occurrence has been reached
   - 084 – this procedure required prior authorization and none was identified
   - 4SL – payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider

   Explanation of benefits dated November 3, 2008
   - OQO – services are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service
   - 0RN – original payment decision is being maintained. This claim was processed properly the first time
   - 4SZ – the time limit for filing has expired
   - 06J – procedure not reimbursable during same visit for the similar service

Issues

1. Did the respondent support its denial reason "4TF – charges exceed your contracted/legislated fee arrangement"?
2. Did the requestor submit documentation to support that preauthorization was requested for physical therapy services required under 28 Texas Administrative Code §134.600?
3. Are CPT codes 99213 and 98940 unbundled? Is a modifier allowed?
4. What is the timely filing deadline applicable to the medical bill for the service billed on September 2, 2008?
5. Is the requestor entitled to reimbursement for the services in dispute?

Findings

1. The respondent denied the services based on reason code "4TF - Charge exceed your contracted/legislated fee arrangement." A review of the explanations of benefits does not indicate a reduction amount taken. The respondent did not clarify or otherwise address the '4TF' claim adjustment code upon receipt of the request for dispute resolution, nor was documentation provided to support a contractual agreement. For these reasons, the division finds that the '4TF' claim adjustment code is not supported and the disputed services will be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.600 (p)(5) states "Non-emergency health care requiring preauthorization includes physical and occupational therapy services…(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury."

    - 28 Texas Administrative Code §102.3 states, "in counting a period of time measured by days, the first day is excluded and the last day is included." The date of injury is June 27, 2008 (Friday) so the 'first two weeks immediately following the date of injury' begins on Saturday, June 28, 2008 and ends on Saturday July 12, 2008. Division rule at §102.3 further states, "if the last day of any period is not a working day, the period is extended to include the next day that is a working day"; therefore, the end of the first two week period after the date of injury is Monday, July 14, 2008.

    - Therefore, physical therapy rendered from July 15, 2008 through October 1, 2008 required preauthorization.

    - The respondent states in its position summary, "The Carrier paid for physical therapy for the first 6 visits. Therefore, all other physical therapy treatments were denied beginning on 7/16/08 as preauthorization was not obtained. Because preauthorization was not obtained for the physical therapy sessions provided from 7/16/08 through 10/1/08, reimbursement should not be owed."

    A review of the documentation submitted by the requestor does not support that preauthorization was requested or obtained for the physical therapy services rendered July 15 through October 1, 2008. No reimbursement can be recommended for these physical therapy services.

3. On July 1, 2008, CPT code 99213-25 was billed with CPT code 98940 (not in dispute). In order to determine proper reimbursement, CCI edits were run in accordance with 28 Texas Administrative Code §134.203 (b)(1) which states: "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - The edit reads as follows: "CCI edit procedure [98940] and component procedure [99213] are unbundled. The Standard Policy Statement reads 'CPT Manual and CMS coding manual instructions'. The use of an appropriate modifier may be allowed. CCI edits indicate that procedure [99213] should not be billed on the same date of service as procedure [98940] without modifier -25." The requestor billed with modifier -25; therefore, reimbursement is recommended.
4. The reconsideration explanation of benefits dated November 3, 2008 raises the issue of timely filing based upon reason codes "OQO – services are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service" and "4SZ – the time limit for filing has expired."

- 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code 408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The requestor states they sent the bills in question to Amerisure Mutual Insurance. 28 Texas Administrative Code 102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

- 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

- Per 28 Texas Administrative Code §102.4(h) (2), the date of the audit (November 3, 2008) minus five days equals October 29, 2008. The Division concludes that the medical bill for disputed date of service September 2, 2008 was submitted timely according to Texas labor Code §408.027(a).

- Therefore, CPT code 98940 billed on September 2, 2008 is eligible for review. The respondent also denied payment for this CPT code due to "06J – procedure not reimbursable during same visit for the similar service." The requestor billed CPT codes 97112, 97012, and 97010 on the same date of service. CCI edits were run in accordance with 28 Texas Administrative Code §134.203 (b) (1). No edit conflicts were found; therefore, reimbursement is recommended.

5. The requestor is eligible for reimbursement for CPT code 99213-25 billed on July 1, 2008; CPT code 97032-59-GP billed on July 3, 2008; CPT code 97112-59-GP billed on July 11, 2008 and CPT code 98940-AT-GA billed on September 2, 2008. Reimbursement is calculated as follows:
   - CPT 99213: $52.83 (DWC conversion factor) ÷ $38.087 (Medicare conversion factor) x $56.34 (participating amount) = $78.15. The requestor seeks $65.00, this amount is recommended.
   - CPT 97032: This CPT code was billed along with CPT codes 97140, 97530, 97012, and 98940 (these codes are not in dispute). In order to determine proper reimbursement, CCI edits were run. No edit conflicts were found.

     $52.83 (DWC conversion factor) ÷ $38.087 (Medicare conversion factor) x $14.77 (participating amount) x 2 units = $40.97. The requestor seeks $40.00, this amount is recommended.
   - CPT code 97112: This CPT code was billed along with CPT codes 97012, 97032, 97010, and 98940 (these codes are not in dispute). In order to determine proper reimbursement, CCI edits were run. The edit reads as follows: "Procedure [98940] and component procedure [97112] are bundled. The Standard Policy Statement reads 'Standards of medical/surgical practice'. The use of an appropriate modifier may be allowed." The requestor billed with modifier -59; therefore, reimbursement is recommended.

     $52.83 (DWC conversion factor) ÷ $38.087 (Medicare conversion factor) x $26.61 (participating amount) x 2 units = $73.82. The requestor seeks $70.00, this amount is recommended.
   - CPT 98940: $52.83 (DWC conversion factor) ÷ $38.087 (Medicare conversion factor) x $22.96 (participating amount) = $31.85.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by both parties during dispute resolution and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is

determined that the documentation submitted supports reimbursement only for the services outlined in paragraph #5 above. As a result, the amount ordered is $206.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement as noted above for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $206.85 plus applicable accrued interest per 28 Texas Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.